Annual Public Hearing: Health Care Cost Trends

Bunker Hill Community College

June 4, 2012

Introductory Remarks

BOROS: Happy to be -- ready to kick off the third annual cost trends hearings for 2012. Welcome to Bunker Hill Community College. My name is Áron Boros, and I'm the Commissioner of the Division of Health Care Finance and Policy. The Division is convening these hearings as an opportunity to further examine the health care challenges and some of the innovative solutions facing the Commonwealth today.

The Commonwealth has consistently been a national leader when it comes to health care. Today's hearings are a great example of how the aligned efforts of many individuals and institutions can come together to make change. To that end, I want to make sure that I acknowledge the many people who made these hearings possible. First, I wanted to recognize the leadership and support of Governor Patrick and his team, and Secretary Bigby and her staff, who were instrumental in shaping not just the agenda that we've put together for the next three days, but really for shaping the conversation around health

care for the last eighteen months and the last six years. I also want to thank the Attorney General. Although she is unable to be here in person today, my office has coordinated closely with hers throughout this process, and the input of Tom O'Brien and his staff has improved our focus and the presentation of these hearings substantially.

I would also like to thank the Legislature. These hearings are convened under the direction of the General Laws, and provide a unique opportunity to examine health care issues in ways not possible through other means. The creation of these hearings under Chapter 305 was an act of foresight that continues to bear fruit. And then I especially want to thank Senator Richard Moore, who is here today, Representative Steven Walsh, who unfortunately had to leave but was here earlier, and any other public officials who will be able to join us later today. The cost trends hearings over the last two years have been one of the many inputs into the activity that you are all aware of today, with respect to the cost containment bills.

Thank you too, to our hosts here at Bunker Hill Community College, including President Mary Fifield. We greatly appreciate how you are able to accommodate us. We have many requests and you have a great deal of flexibility and resourcefulness, so thank you. Finally, I want to

especially thank my staff. In particular, Acting Assistant Commissioner, Miriam Drapkin, and Christina Wu, both of whom have gone above and beyond the call of duty in preparing for the next few days. Anything that goes well in the next few days is to their credit. Anything that is a mix-up or a delay, is no doubt due to my error. So please give them all the credit for this event.

As I said, today's hearings are the result of the aligned effort of many. Thank you all, for your continued support and your efforts to support both the cost trends hearings and the greater effort of improving the health care system. The team effort that goes into the hearings today is an apt analogy for the team effort that will be required for us to succeed in maintaining and improving access, maintaining and improving quality, and ultimately reducing cost.

I want to give you a brief overview of what's going to be happening over the next few days. We're going to hear this morning, from Governor Patrick and a number of other public officials. We are then going to break for lunch, and then this afternoon at 1:00, we'll be having an expert panel on the delivery system, and thinking about how care integration can help achieve the aims that I have just outlined. Tomorrow, we'll reconvene at 9:30 in the morning

for a multi stakeholder panel, with perspectives on the recent shifts in the health care marketplace, including some of the shifts that have been promoted by legislation, including Chapter 288 of the Acts of 2010, and some other changes that are going on in the health care marketplace. We'll have a keynote address at lunchtime tomorrow, on the integration of behavioral health and primary care, and tomorrow afternoon we'll have a panel to discuss recent shifts in the health care marketplace, from the perspective of other providers and consumers, looking at how the move towards integrated care and global payments affects different players that you hear from hospitals and from large physician groups. Finally, on the morning of June 6th, we'll have the opportunity for public testimony. If you're interested in providing public testimony, we ask that you arrive at 8:30 in the morning on Wednesday, the 6th, to sign up. Testimony will be limited to five minutes per person, and you can register at the front desk.

With that, I have the pleasure of introducing Secretary JudyAnn Bigby. Secretary Bigby is the head of the Executive Office of Health and Human Services of the Commonwealth, and she oversees 17 agencies, including the state's Medicaid program and my agency, the Division for Health Care Finance and Policy. She was -- the agencies of

EOHHS were partners and responsible for implementing many of the features of the 2006 legislation, many of the features of subsequent legislation in 2008 and 2010. Prior to her appointment as Secretary in 2007, Dr. Bigby served as a Primary Care Physician and Director of Community Health Programs at Brigham and Women's Hospital in Boston. She also served as Associate Professor of Medicine at Harvard Medical School, where she was the Director of the Harvard Medical School Center of Excellence in Women's Health. Dr. Bigby is currently on the board of directors of the National Quality Forum, holds a BA from Wellesley College and an MD from Harvard Medical School. So please, join me in welcoming Dr. JudyAnn Bigby.

Comments From Public Officials

BIGBY: Good morning everyone. Thank you very much Commissioner Boros. It's really great to be here at the third annual cost hearings. I want to also thank both Chairman Moore and Chairman Walsh, for their continued leadership in the Legislature and their commitment to health care reform. I want to say a few words before I have the honor of introducing Governor Patrick.

We all know the milestones that we've achieved in Massachusetts as part of the 2006 legislation; near universal coverage, improved access for particularly, disadvantaged and vulnerable populations, almost a hundred percent of children covered in Massachusetts, and in the face of that, we've sustained world class health care. We should be proud of all these achievements, but we know that there is more to do. In order to make sure that health care in Massachusetts is truly accessible and affordable, and to achieve the high quality of care that everyone deserves, we need to go on to the next phase of health care reform in Massachusetts. If we don't, the achievements that we've seen will not be sustainable.

I'm very grateful to Commissioner Boros and to his team at the Division of Health Care Finance and Policy, and I want to thank you for your efforts to make these hearings informative and meaningful. The Division recently released the annual report on health care costs in Massachusetts, and the report tells us why we need to continue to control costs, and that this must be a key priority as we move forward. Every economic indicator that we have shows that health care cost is outpacing the rest of the economy. While this might not be surprising, it's worth repeating.

We cannot do tomorrow what we're doing today. It simply will be unsustainable.

We need to think comprehensively about how to transform the health care delivery system and to decrease costs while maintaining access and improving quality. And I know that everybody here knows this, there simply is no silver bullet; otherwise we would have solved this problem, right? We know however, that we can see changes that result in decreasing health care costs, but we also know from the past, that by simply tinkering around the edges, we can see a short-term decrease in health care cost growth, but then it just goes back right up to where it was before. We do not want to repeat the type of interventions that we've tried in the past, that we know are only temporary solutions.

We need a health care system that aligns incentives to providers, with achieving improved health outcomes, greater access and quality, at lower, sustainable costs. Integrated systems of care are key to ensuring that health care is structured to achieve value, and we must support the transformation of our payment structures to promote this integration. Within state government, we have begun to do just that. Mass Health is in the second year of supporting the Patient-Centered Medical Home Initiative.

This initiative, in partnership with commercial payers, is paying primary care providers to provide integrated, preventive and primary care, chronic care management and coordination. Practices across the state are participating with the goal of improving outcomes for conditions such as diabetes and asthma, and attention deficit disorder in kids. We also know that this approach will prevent unnecessary emergency visits and hospitalizations. Around the country, this model has been shown to improve the quality of care and reduce cost.

Mass Health will also soon release a call for sponsors to our proposal for integrating health care and independent living, and long-term services and supports for people who are duly eligible for Medicare and Medicaid. This demonstration, supported by the Affordable Care Act, will result in a truly transformed system of care for these individuals, and it will achieve significant savings and better results from the $4 billion we currently spend on this population. The savings will come not from denying services of care, but by addressing the well described waste in the system that results in unnecessary, avoidable hospital admissions, emergency department visits, and by better use of appropriate medications. We're also exploring how Mass Health can contract with structures to

support providers who want to become accountable care organizations.

The ultimate goal of integrated delivery systems is to provide a strong foundation of care that can adapt to the needs of different populations. It has to be informed by the best evidence for value and efficiency and improve patient outcomes. That's why we need flexibility in the way providers and others begin to implement these reform systems. We still have a long way to go in Massachusetts before comprehensive integrated delivery systems become a reality, but that is why we must focus our efforts on redesigning the current system and reforming the way we pay.

The Legislature has done exceptional work in the recent months, building off the cost containment bill that Governor Patrick filed last year. These efforts can ensure that the Commonwealth is on the road to meaningful transformation of health care payment and the delivery system. I know that over the next few days, you'll hear diverse opinions about the strength of some of these proposed initiatives to control cost and improve care. We'll hear from experts and stakeholders already engaged in delivery system transformation, and hear about promising results, but we'll also hear about the challenges. We'll

also hear from providers who typically have been left out of conversations that impact their role in health care, and get their perspective on what tools they need to participated in integrated delivery systems so again, we can provide care for the whole person, not just diseases or body parts or silos, the way the current system is largely designed.

I'm really excited about the wealth of information that will be presented over the course of these hearings. Again, thank you Commissioner Boros, for bringing this group of informers to us, in a very knowledgeable way that we can use this information to inform our path as we pursue these changes. And now I'd like to introduce Governor Patrick. He's someone who has made health care reform and cost containment the state's top priority. Not because it's so much about saving money, but he knows that our efforts are really vital to making sure that we have a vital Commonwealth, that people are well served, and that we can be the best state in the nation in terms of having healthy people who are contributing to their communities and who will be the future of the state of Massachusetts. Please join me in welcoming Governor Deval Patrick.

PATRICK: Thank you very much Secretary Bigby. I thank you and Commissioner Boros, Commissioner Murphy, all the members of the administration who are here, I want to acknowledge as well. Senator Moore, who has done, as the Secretary said, extraordinary work on this subject from the beginning, and in this next chapter of health care reform and in his absence, Chairman Walsh as well. And I thank all of the participants in these hearings, for keeping the focus on the critical issue of lowering health care costs here in Massachusetts.

Everybody acknowledges that health care costs are growing at an unsustainable rate. Nationally, spending on health care increased 6.5 percent annually in the last ten years, while real incomes fell in the period by more than 7 percent. In Massachusetts, per capita health care spending has grown almost three times as fast as median family income in that same period. The problem predates and is unrelated to health care reform in Massachusetts, and it's unsustainable. It's also, it turns out, unnecessary. Experts estimate that as much as 20 to 30 percent of current health care spending is wasted on over-treatment, avoidable hospital readmissions, preventable errors, unnecessary administration and things like that. Spending on health care is $67 billion here in Massachusetts every

single year. Every single year. So that means you and I spend somewhere between $13- and $20 billion every year that we don't have to. The unhealthy choices we make in our own lives also add to that cost, and we all pay for it, with or without a system of university access.

A lot of good work has gone into identifying and addressing these issues over the years. Secretary Bigby referred to some of it. I expect over the course of the hearings, you'll hear more of it. There is clearly more that we can do. Everyone has acknowledged the problem and everyone has worked on parts of the solution, and it's working. We are certainly bending the cost curve here in Massachusetts and I'm sure as I say, you'll hear more about the many examples of this in the course of these hearings.

Now some say that the recession is the reason or explains the results that we're getting, but most health care economists agree that there is more to it than that. That's especially clear when you consider that most of the cost improvement occurred not during the depth of the recession but during the time when we got serious about confronting this challenge together. You also hear assurances that the market has been moving in the right direction, and indeed it's true that the market has been moving in the right direction, but the market didn't start

moving all on its own, and we'd better be clear about that. Government took action. We started, under the Commissioner's leadership, by pushing back against insurance increases, and then worked hand in hand with insurers and businesses, to create limited network plans and small business co-ops, and are working today with hospitals, community health centers, doctors and other providers, to pilot patient-centered medical homes, using tools that the Legislature has given us over the last couple of years. The fact is that we have seen progress because both the private sector and government are working at it, and that is critical to keep in mind.

To sustain that progress, we need health care cost legislation. Last month, the Senate voted on their version of the bill, the House will debate and vote on theirs this week. The Leaders are committed to getting me a final bill this session. What I am most focused on is the impact on working families and businesses across the Commonwealth. I make that point because this is a complex area and folks come with different perspectives about the complexity of this area, and different ways in which we should move this or that element of the complexity. But we need to keep our focus on what the impact is on people who pay the bills; working families, small businesses, large businesses,

municipal government, state government. How do we contain those costs and the impact there? Are they going to feel a difference? When they sit down to do their budgets, can we assure that health care spending won't grow twice as fast as everything else, forcing choices between paying those bills and making other investments? Will the new model of integrated care be patient-centered, easy to navigate, and lead to healthier outcomes?

I want to thank the Senate President, the Speaker, Chairman Walsh, Chairman Dempsey, Chairman Moore, and all of the members of the Legislature, for the impressive, creative and thoughtful work they are doing to address these questions. I also want to thank the many, many stakeholders, some of whom are represented here today, who have worked with us to refine our thinking and improve specific language in the bills. Business leaders, hospitals, insurers, doctors, nurses, community and public health leaders and patient advocates, have committed to work together on a solution. That's how we've made so much progress in the past six years and how we're making so much progress on this chapter.

As the Legislature completes its work, I want to reiterate the core principles that I expect to see reflected in a final bill. They are:

1. A cost containment goal.
2. Flexibility and how to achieve it.
3. Accountability for doing so.
4. Sensible tort reform.

On the first two and the last one, I believe the versions are close. I believe we will agree to a cost containment goal that is both ambitious and reasonable, and that we will have both a timeline and means to achieve the goal that are flexible. I also believe we will have strong tort reform provisions in the final bill. On accountability, I want to especially note that the House made significant progress in their bill, reported out by Ways and Means last week. Instead of establishing an unaccountable new agency, the new version of the House legislation repurposes an existing one; the Division of Health Care Finance and Policy, coincidentally, and consolidates in it, certain powers of other state health care agencies. That simplification seems right to me. The version of oversight board the House has proposed also ensures accountability to the administration and most importantly to the public. These and other refinements of

the new version of the House bill, I believe are positive steps forward.

While on the subject of accountability, I should note that the House version has a number of features to address market power and concern about the effect of market power on health care costs. While I am not yet convinced that the best solution is a so-called luxury tax, I do believe that clarifying, and if necessary enhancing the authority of the Attorney General to address the cost impact of market power, and I mean everybody's market power. Providers, payers, other players in the industry, should be a part of financial legislation.

Finally, let me just say as I have before, that the health care industry is important to Massachusetts and important to me personally. I have had personal experience with different parts of the system and I am amazed at how much good work is done, how dedicated the people are, and how lucky we are to have such a robust industry here. No one, least of all me, wants to cause undue harm to the industry. The reason to lower costs is to improve economic competitiveness for everyone, not to harm it, because the goal is worthy and the people at the table, from the health care industry and beyond, are smart and well intended. I am confident that we will reach a good legislative

conclusion together in the next few weeks, and that the future of the health care business in Massachusetts is bright indeed. Thank you very much and good luck with these hearings, thank you for holding them.

BOROS: I apologize, I'm fighting something, so. Before I introduce our next guest, I want to thank Attorney General Coakley. Although she was unable to attend today, as I mentioned earlier, she's been an instrumental part of the experience of putting together these hearings. She has also submitted testimony for the record, that will be available on the Division's website today. So, I want to follow up on Governor Patrick's remarks in thanking the reaction of the Legislature to the legislation that he filed almost 18 months ago, and taking the challenge of cost containment in the health care system seriously.

Senator Richard Moore has been an instrumental part in that effort. Senator Moore represents 14 Central Massachusetts towns. As Senate Chairman of the Committee on Health Care Financing, he has been at the forefront of issues affecting the health of people in Massachusetts for more than a decade. His imprint can be found on nearly every piece of health care legislation enacted in Massachusetts during the past decade, including the cost

containment bill that was passed last month. With that, I'd like to introduce Senator Moore to make some remarks, and ah, Senator Moore.

MOORE: Thank you very much Commissioner and thank you for the opportunity to appear before you today to discuss ongoing efforts to restrain the growth of the cost of health care in Massachusetts, in relation to the Division's health care cost growth trends. In addition to these remarks I've provided, we'll provide the Division with some additional details and testimony. I would say that unfortunately, my counterpart in the House, Representative Walsh, has had to leave, but he did say that whatever I say, he'll agree to. So you can be sure it will be a quick conference, since that's the case.

In the few moments that I have to discuss health care cost trends with you, I want to underscore first, why this matters to the economic health of the Commonwealth and its political subdivisions, and to every individual and corporate taxpayer today and in the future. Secondly, why we must not defer meaningful action to contain health care cost growth, even if the solution is not deemed perfect by everyone. And third, what the Legislature, especially the Senate, intends to do in response to -- through a

responsible, comprehensive strategy, to achieve the goal of reducing the growth of health care cost claims and health insurance premiums.

First, why containing the rise in health care costs and related insurance premium matters to our economic health, is clear from the May, 2012 report of the Massachusetts Health Care Cost Trends, prepared by the Division of Health Care Finance and Policy. The report's executive summary, found on page one, states clearly, "Health insurance premiums, cost in Massachusetts and the Northeast Region, are among the highest in the nation, placing a substantial burden on consumers and employers." Massachusetts spends 15 percent more per person on health care than the rest of the nation, and about 40 percent of our state budget is on health care, squeezing out resources that are urgently needed to address other public priorities such as education, transportation, energy and the environment.

Perhaps the good news is that Massachusetts has slipped from first place in health insurance premium costs, to ninth, among the 50 states in the District of Columbia. That's a healthy trend. There are several reasons that have been offered to explain this new ranking. The cumulative impact of the Commonwealth's health care reform

efforts, the near universal coverage and the improved health ranking of health status in Massachusetts. Secondly, the changing dynamics of the health insurance marketplace as payers and providers work to reduce administrative costs and improve quality outcomes, including some shifting to global payments to reward value over volume of care. There are the impact of administrative limitations on increases in premiums, through disapproval of rate increases deemed excessive by insurance regulators and/or the drop in utilization of health care services because of the recession and the sluggish economic recovery, that has caused consumers to defer seeking care and businesses to shift costs to consumers through the increased co-pays or deductibles. It's possible that all four factors contributed to the shift in our standing among the states, to one degree or another, but the fact remains, that even in ninth place, the rising costs of health insurance and health care remains unacceptably high.

A primarily regulatory approach is not the best answer. Arbitrarily capping of insurance rates cannot be viewed as a long-term solution, since this fails to directly address actual rising costs without harming quality and access. Such rate capping also ultimately

shifts costs in other directions. We certainly don't want to shift the cost growth burden disproportionately to consumers, to the point that access is reduced or that attention to health conditions are deferred until those health conditions become more serious and the needed care becomes more expensive. Second, there appears to be a growing consensus that it's critical that we take action to slow cost growth now. Any sustainable solution to rising health care costs that also limits any adverse impacts on a slowly recovering economy will take time, but we need to begin, just as a long journey begins with a few steps.

Economists have told us that as insurance costs for employees continues to grow, the ability of businesses to expand, to maintain employment, to hire new workers, to invest in innovation, and to produce a reasonable return to attract investment is limited or even thwarted. A sustained economic recovery depends on keeping health care costs from rising faster than inflation. Making health care costs affordable helps consumers to retain access to the care that they and their families need to remain productive workers. Some health care stakeholders and observers have argued that there's no need for state action, since the health care marketplace appears to be moving in the direction of cost containment and global

payment methodologies. However, those market forces are not evenly at work throughout health care, and they are likely to slow down in the absence of outside pressure, primarily from government. Certainly a credible argument can be made that the market might not be moving at all, or certainly not as fast, if government had not signaled the willingness to address payment reform. It is critical, I believe, to keep the reform advancing, to incentivize value over volume, and to expand it across the entire health care marketplace.

On June 27, 2011, at last year's cost growth hearings, I stated, and I quote, "As those in state government, stakeholders and the public discuss the need for the very reform we're considering, in the Committee on Health Care Financing, that discussion has focused on containing the rising costs, or trying to keep the cost increases below the level of medical inflation." During the intervening year, the Senate adopted the plan, Senate Bill 2270, and the House is currently considering its version of health care payment reform, to bend the escalating health care cost curve, in order to bring it more into line with the overall rate of inflation in Massachusetts, or gross state product. The goal of the initiative adopted in the Senate, by the Senate in May, is to reel in the health care costs

without harming our number one industry or patient care, and to remove a major roadblock to long-term job growth and essential investments in education, transportation and other urgently needed public priorities. The most important goal of our legislation is to reduce the cost of health care while ensuring continued access and improved quality outcomes.

For the first time in the nation, the Senate initiative establishes a statewide health care cost growth goal for the health care industry, equal to the projected growth of the state's gross product, plus a half percent, from 2012 to 2015, and then equal to the state's gross state product beginning in 2016 and thereafter. While the total amount of savings is speculative and subject to debate, regarding the actual savings, leading economists tell us that this will produce significant savings, in the billions of dollars and arguably, at the amount of about $150 billion over the next 15 years. Savings which will be passed on to businesses, municipalities and the residents of the Commonwealth who are struggling with increasing premiums and other health care costs. Given the fact that setting such a goal has never been attempted before, here or anywhere in the United States, as throughout the Commonwealth, the Senate believes that we should implement

a reasonable degree of caution. Health care is such a major part of our economy and miscalculation could seriously set back the Commonwealth's economic recovery; a recovery that is unsteady and that could easily be undercut by the current instability of our trading partners in Europe or by draconian budgeting in Washington. Certainly, the highly regarded Massachusetts Taxpayers Foundation shares this need for caution.

We reject, as irresponsible, the calls from some members of the business community, the faith community or government, for cost growth that is below the rate of inflation, as long as inflation remains at the modest pace that we've experienced in recent years. We also disagree with those who doubt the need for an independent agency to oversee adjustments in the cost growth goal. We believe that in order to gain public trust and acceptance by stakeholders, the oversight of the implement to the cost growth goal must not be subject to the political agenda of any future state administration, and that recommendation for revisions to the goal need be as objective and as professional as they possibly can be.

In an effort to carefully balance the need to transform the health care industry without harming the number one employment sector in Massachusetts, the Senate's

initiative supports health care professionals in developing innovative payment and care delivery models, and establishes tools for health providers to meet the targets in the bill through market based solutions. It is the position of the Senate that the payment reform initiative that we've advanced, will address the current problems of premiums and claims growth that exceeds inflation, by bringing these costs into line with inflation in a reasonable manner, allowing the economy to adjust without serious detriment to the state's recovery. We also believe that the mechanisms that would be put in place in the Senate initiative, will reduce those aspects of price variation which are unacceptable, such as market power, without corresponding regard to quality of care. It was after all, the conclusion of the special commission on provider pricing, that we should be -- that it should be the responsibility of an independent expert panel, not bureaucrats using arbitrary formulas rigidly applied, to sort through the complex reasons underlying variations of cost among providers.

I share the Division's interest in utilizing total medical expense as a standardized gage of global medical spending on a per member per month basis. The further analysis of this metric and the development of its

appropriate application, is precisely the objective evidence based research that the Senate initiative and visions for the work of an independent institute for health care finance and policy.

As you know, the House of Representatives is currently working on a plan this week, to contain the growth in health care costs, and we wish them well as the process unfolds. Given the rare editorial agreement by the two leading newspapers of record in this capital city, that there are more positive concepts in the Senate version than those initially proposed by House Leaders. We hope that the version finally adopted by the House will offer a speedy resolution of differences between the Senate and the House plans for payment reform. In any event, I'm confident that the debate this week, as well as comments offered at these cost growth hearings, will inform the discussions of the anticipated conference committee, as the Legislature develops a final plan for bending the health care cost curve downward.

Nearly 400 years ago, Governor John Winthrop described Massachusetts as, "A city upon a hill, with the eyes of the world upon us." In the area of health reform at least, we continue to be that city upon a hill in the eyes in the nation, at least those involved in health policy are surely

upon us as we travel largely uncharted waters of health care payment reform. The course being charted for cost growth containment is intended to steer clear of rough seas and rocky shoals, and bring us to the safe harbor of improving quality of health care and reducing the cost through increased transparency, efficiency and innovation. I look forward to the input that's provided over the next three days, as well as the -- we'll follow closely, the debates in the House of Representatives, as we begin to analyze what needs to be in the final bill that we will send to Governor Patrick, hopefully before the middle of July, but certainly before the end of the formal session, so that he has the opportunity to weigh in on the provisions that we've included. Thank you.

BOROS: Thank you Senator Moore. As I mentioned earlier, the effort of cost containment and health reform more broadly, is a team effort, and Governor Patrick, Secretary Bigby and Senator Moore's presence here today testifies to that. Certainly, when you try to list the number of state agencies that are involved in the overall effort of containing cost and improving quality, improving access, it's difficult to come up with a comprehensive list.

Commissioner Joe Murphy is here today, from the Division of Insurance. Certainly, they would end up on any list that you tried to create. Commissioner Murphy's -- under Commissioner Murphy's leadership, for the first time in history, the Division of Insurance exercised its statutory authority to scrutinize proposed health insurance rates, last year, resulting in savings of over $100 million for Massachusetts businesses and working families. Commissioner Murphy joins us here today. His remarks.

MURPHY: Thank you Commissioner Boros. This morning I'd like to talk briefly about developments with respect to the insured marketplace in Massachusetts over the past year. I will be -- I will emphasize brief, because I think, looking at the agenda, I'm the only thing between lunch and the real work of this afternoon's panels. As you all well know, Governor Patrick and all of us in the administration are especially concerned about the cost and availability of health insurance in Massachusetts. Here in Massachusetts, we are blessed to be in the middle of what we call the medical Mecca. We have some of the most technologically advanced hospitals, best trained health practitioners, and top ranked health insurance carriers in the nation and indeed in the world. These blessings are accompanied by

the challenge of ensuring that patients get the right care, at the right institution, and in order to ensure the right cost. Otherwise, the galloping costs of health care will continue to threaten the viability of our small businesses and the financial future of our families.

Since the passage of our landmark health care reform legislation in 2006, we have made remarkable strides in coverage, reaching almost universal coverage, with nearly 99 percent of both adults and children now having health insurance. We are now focusing our energy on making progress around cost containment. Two years ago, we saw proposed health insurance base rate increases of around 16 percent. Today, those same base rate increases are averaging less than 1 percent. Insurers have responded with creativity and commitment to the call for more and better product offerings. We are seeing a wider range of plans, which means more options for employers and consumers. These included limited network products, which offer financial incentives to consumers using community facilities, rather than academic medical centers, for their more everyday health care needs. They also include the approval of the first two small business purchasing cooperatives, giving small employers another route to more affordable health coverage.

Our collaborative work has resulted in near universal coverage for our residents, as well as a drop in health premiums, from the highest in the country in 2008 and 2009, to the ninth most expensive in 2010. That is real progress but there is more to be done to contain the costs in our health care system. This week, the House of Representatives will take up their version of cost containment legislation, and they will debate many of the ideas that Governor Patrick included in the legislation he filed in February of last year. This is an effort to fundamentally change the way we pay for health care, by focusing on quality rather than volume.

The Division of Insurance continued to focus its resources and expertise to partnering with agencies throughout the administration, as well as external stakeholders, to explore new cost containment opportunities and to increase the affordability of health coverage for our consumers. In closing, I look forward to these important hearings over the next few days, as well as our continued work together on these critical issues in the weeks and months ahead. Thank you.

BOROS: Thank you Commissioner Murphy. Thank you all of our speakers this morning. With that, we will adjourn for

lunch, and we will be reconvening at 1:00 this afternoon for our first hearing and discussion on the integration of care as part of the solution. Thank you.

Expert Panel Discussion on Delivery System Integration

BOROS: Welcome back. If you were here this morning to hear Governor Patrick and out other guests speak this morning. Thank you for joining us for day one of the cost trends hearings for 2012. This afternoon, we are going -- we are joined by an esteemed panel of guests, to talk about the challenges of care integration and the opportunities of care integration; how to measure care integration, the kinds of rewards that you might reap if you are successful in building bridges between different kinds of providers and really enhancing the patient's experience of care.

I'm going to very briefly introduce our panelists, and my co-conspirator here, and then we will move into the panel itself. Perhaps as I introduce people, I'm going to ask, as part of the hearing format, ask my colleague, Christina Wu, to swear in the panelists. And actually, I suppose we can do this all at once.

WU: Yes.

BOROS: So why don't you start. This is the first time we've done this, this year, so bear with us, and then we'll introduce you.

WU: Will you all raise your right hand. Do you solemnly swear that the testimony you are about to give in the matter now at the hearing, will be the truth, the whole truth, and nothing but the truth?

PANELISTS: (answer in the affirmative).

WU: Please identify yourself by raising your hand if your testimony today are limited for any reason, if there are any restrictions placed on the capacity in which you testify today, or if you have any conflicts of interest that require disclosure. OK, thank you.

BOROS: So I will move from left to right here, across the panel, and quickly introduce, and then each panelist is going to have an opportunity to make a prepared statement.

Gregory Pope is the director on the program on health care, financing and payment, at RTI International. Mr.

Pope led the implementation and evaluation of the Medicare physician group practice demonstration and is working with the Federal Government to implement ACOs in Medicare, accountable care organizations in Medicare.

Dr. Richard Lopez serves as Chief Medical Officer of Atrius Health. In addition to seeing patients, he focuses on clinical program and regional project development, clinical aspects of payer-provider contracting, clinical informatics, medical management, and safety and quality, as well as collaborating to develop quality standards. Dr. Lopez sits on the statewide quality advisory committee with me, that's working to develop a statewide quality measure set.

Mr. Steve Bradley serves as the Vice President for Government and Community Relations and Public Affairs, at Baystate Health. He is responsible for developing Baystate's legislative and political strategy at the federal, state and city levels, and he informed you earlier that he is a proud alum of the state government as well, where he worked for the DDS, the Department of Disability Services.

Ms. Frederica Williams is the President and CEO of Whittier Street Health Center. In that position, as well as several other initiatives, she works to enhance the

community's ability to provide high quality, reliable and accessible health care, and support services to the elderly, disabled, immigrants, children, and the uninsured and under-insured.

And finally, Mr. Jack Kelly has been Vice President with the -- is the Vice President of the Central Massachusetts Independent Physician Association for over a decade. A practicing physician, he also serves on the Central Mass IPA, Total Accountable Care Organization Steering Committee, which if I got wrong, I'm sure he will correct me.

And I'm joined by Lois Johnson, who is with the Office of the Attorney General. The format of this hearing is we're going to have the three to five minute prepared statements. My colleague, Joe Vizard is going to help the panelists be aware of the time, and then we have some questions that we'll be asking of the panelists. We will also have an opportunity -- excuse me. We also have an opportunity to ask questions that the audience members are interested in providing, so Dorothy and Julia are going to be -- Dorothy raise your hand -- and Julia, are going to be collecting note cards from the audience, if you have questions. We probably won't have a chance to ask all of those questions, but we may have a chance to ask some, so

please send those up during -- as we're speaking. So with that, I will turn it over to Mr. Pope. And you're welcome to make your statement from where you're sitting.

POPE: Are these live?

BOROS: Yes.

POPE: OK, great. I'll be very brief and just introduce myself and save substantive comments for the discussion. So as Áron said, I'm director of the program on health care finance and payment, at RTI International. RTI is a nonprofit research organization headquartered in North Carolina. The RTI stands for Research Triangle Institute, in the Raleigh, Durham area, which some of you may know. RTI does mostly contracting grant work for the Federal Government. I'm based in RTI's regional office in Waltham, where we have about 80 employees, focused mostly on health policy research. I'm an economist and did my graduate work in economics at the Massachusetts Institute of Technology and my areas of expertise are health economics and health policy.

Over my career, most of my work has focused on federal Medicare health insurance program for the elderly and

disabled. My current work, as Áron mentioned, focuses on accountable care organizations and also on the state health insurance exchanges under federal health care reform. I'm leading a team at RTI that is working with the Federal Government to implement ACOs in Medicare, including several pioneer ACOs in the Boston area that began operations in January of this year. I also led the implementation, support and evaluation of a precursor to ACOs; the Medicare Physician Group practice demonstration, which I understand is going to be one of the topics of discussion today and one reason I was invited to participate. I'm also currently working with the Federal Government on so-called risk adjustment payment methods to level the payment field for exchange based insurance plans under health reform, as they enroll or sicker members.

So I'm glad to be here today and participate in the discussion, and I look forward to it. So I'll stop there, thank you.

LOPEZ: Good afternoon Commissioner Boros and Lois Johnson and guests. My name is Richard Lopez. I'm the Chief Medical Officer for Atrius Health and a practicing internist at Harvard Vanguard Medical Associates in Medford. Thank you

for inviting me here to comment on the topic of integrated health care delivery systems.

Atrius Health is a not for profit alliance of six leading community based medical groups, that includes Dedham Medical Associates, Granite Medical Group, Harvard Vanguard Medical Associates, Reliant Medical Group, which is the former Fallon Clinic, South Shore Medical Center and Southboro Medical Group. Our organization was formed to enable collaboration on new and better ways of delivering health care, while maintaining an emphasis on care on the local community. Atrius Health represents a thousand physicians and over 1,450 other professionals, serving about a million patients, adult and pediatric, in 50 locations throughout Central and Eastern Massachusetts. Our physicians are employed by medical groups. We offer over 35 specialties. Half of our practice is primary care and we have over 30 practices certified, I'm proud to say, as NCQA Level 3 patient-centered medical homes.

Atrius Health Group accept most regular health plans, including the Blue Cross, Blue Shield Alternative Quality Contract, and we do not own a health plan. Atrius Health is also independent of a hospital system. We work with about 15 hospital partners, although last year there were 25 hospitals where we had at least a hundred admissions of

our patients. Atrius Health was selected by CMS to be one of the 32 pioneer ACOs with all groups, except for our newest member, Reliant Medical Group, which is not participating this year. The roots of all our groups lie in prepaid health care and managed care. Our largest affiliate, Harvard Vanguard Medical Associates, is the legacy of -- is a legacy group started in 1969 as Harvard Community Health Plan, by Dr. Robert Ebert, who was then dean of the Harvard Medical School. Dr. Ebert said, actually quite prophetically at the time, and I quote, "The existing deficiencies in health care cannot be corrected simply by supplying more personnel, more facilities and more money. These problems can only be solved by organizing the personnel, facilities and financing, into a conceptual framework and operating system that will provide optimally for the health needs of the population."

I think this philosophy still guides us today, in the way Atrius Health works, and we see global payments and shared savings arrangements as enablers of high quality, affordable care. We currently accept global payment or other alternative payment arrangements, for about 65 percent of our total revenue. Under these payment arrangements, we accept accountability for quality and cost of care, for our patients across the continuum, including

specialty care provided outside our four walls, and also for hospital care, post-acute care, pharmacy. To coordinate this care effectively means that we have to develop value by collaborating effectively with hospital partners, skilled nursing facilities, home health agencies, and other agencies such as the aging services access points. We achieve this collaboration by working to hold accountable, each of these entities, to standards of care for our patients, and by the extensive use of care managers to help coordinate the individual patient's care. We believe that a major value that we bring to the market is this type of collaboration on behalf of our patients and the community.

Coordinating care across the continuum for a large number of patients also requires a strong health information technology infrastructure and interoperability. A hundred percent of our practice is on the Epic electronic medical record. We have almost 25 percent of our patients on a patient portal for online access to parts of their medical record, and to secure email with their patients -- with the patient's physician's office. We also have a data warehouse in which we store claims data for patients for whom we accept risk, and sophisticated tools for data analysis and reporting, to support the management of

population health, quality and cost. We've developed, in conjunction with a number of our hospital partners, the ability to see into each others' medical records for specific patients, with a one button link. We are still building these connections and others, such as those with our preferred VNA.

Atrius Health is proud of the Commonwealth's work around access to health insurance coverage, and believe strongly that it's time to tackle cost. We're committed to bringing down the total medical expense for our patients we serve and making progress in bending the trend while improving on a wide range of quality measures. We are supportive of the ongoing efforts in the Commonwealth, to achieve the triple aim of improved patient experience, improved health of the population and reduce per capita cost. We believe that the Commonwealth should move to global payments or shared savings, patient-centered medical homes and accountable care organizations, with each patient linked to a primary provider. The continued dialogue that we have as a community will help us arrive at the best solutions over time, and I'm glad to expand on any of these thoughts at your request. Thank you.

BRADLEY: Good afternoon. I'm Steven Bradley. I'm the Vice President for Government, Community Relations and Public Affairs at Baystate Health. Baystate Health is located, its main hospital is in Springfield, Massachusetts. We have two community hospitals; one in Franklin County in Greenfield, Mass, and another in the city of -- in the town of Weir, which is a short drive off of the Palmer Exit at the Mass Pike. The vision for Baystate Health is to transform health care delivery and financing, to provide a high quality, affordable and integrated system of care that will serve as a model for the nation.

Strategies that we've adopted are to create a customer service environment leading nationally in clinical quality, reducing the total cost of health care, developing innovative patient-centered models of care in partnership with our providers, influencing patients and employees and members to take an active role in their health care, and academic innovation. As we are a teaching hospital at Baystate Medical Center, we're focusing on academics and research and support of clinical innovation and integration. Around organizational effectiveness, we're focusing on enhancing leadership effectiveness and engaging employees with the necessary capabilities to be successful in these changing times.

Baystate Health is a $1.6 billion organization. We had over 44,000 admissions to our hospitals back in 2010, but $1.6 billion in total assets. We are focused on quality. We're nationally recognized for quality care, through the Leapfrog best in top 40. We've been a top 40 Leapfrog organization for the last four years. We own a small HMO insurer called Health New England. It is one of the top ten health plans in the country. It has been voted number one in customer services in the country. And we are in the top 2 percent of hospitals in the country for the establishment and utilization of electronic medical records. We have over 630 physician partners and practitioners at Baystate medical practices. We have 1,200 physicians in our Bay Care Health Partners, which is our physician health organization, which you will see in a recent report that was put out by the Division of Health Care Finance and Policy, as being the second lowest cost in terms of total medical expense providers in the Commonwealth.

We're the largest local employer in Western Massachusetts. We have over 10,000 employees, $2.6 billion worth of economic stimulus is provided by Baystate Health and related activities. We're 9.5 percent of every dollar spent in Hampden County, is generated by Baystate Health.

Seven percent of the total economy in Western Massachusetts is generated by Baystate Health, and we produce 17,400 direct and indirect jobs. We're also a very active partner in the community. We believe that actively engaging our community and improving population health is the best way to reduce cost over the long-term, and in that regard, we are very active with our community benefit programs and our education and prevention programs.

We fund a nonprofit organization called Partners for a Healthier Community, which has been recognized nationally for having approved educational attainment in the Springfield public schools, and we are now following 158 students who have graduated from the Baystate-Springfield educational partnership, have matriculated to college, and we're supporting them through their college careers and we're trying to influence them to take college courses and programs that get them back to Springfield, in the health care field. And we run three community health centers that serve over a hundred thousand visits a year in Springfield, and they serve the poorest neighborhoods in the community.

We're very excited about the work that's going on at the state and federal level, to transform health care from a fee for service focused service delivery system, to a highly coordinated, highly integrated patient-centered,

population based health care. The organization, from the board of trustees, all the way down to our entry level positions are focused on changing the culture within the organization, so that we are focused on measuring our success, based on the improved health of our patients, and more importantly, on the improved health of the population that we serve. Thank you, and I look forward to answering your questions later.

WILLIAMS: Good afternoon everyone. My name is Frederica Williams. Thank you to Commissioner Boros and Ms. Johnson for having us here. It's wonderful to have a community health center represented in this discussion. I'm the President and CEO of the Whittier Street Health Center, a position I've held for ten years. In the time that I've been at the helm at Whittier Street Health Center, the number of people served has increased from 5,000 to almost 20,000. We're located in Roxbury and we serve a large immigrant population, people from 20 different countries. We also serve the largest low income and poor communities in Boston. Thirty-four percent of our patients currently have no insurance. Eighty percent of our patients present with psychosocial issues and 70 percent of our patients have at least one diagnosis of a chronic illness. We're

nationally recognized as an innovative model of care for addressing racial and ethnic disparities in health care, and the social and environmental determinants to health.

Investing in and emphasizing the importance of primary care will help create a more efficient, cost effective, and high quality health care system. Our traditional ways of practicing primary care often do not adequately address how to manage chronic conditions and do little to reward system wide coordination, education or communication. To address these challenges, Whittier Street Health Center began redesigning its delivery systems in 2003, to enhance internal and external coordination, patient and provider satisfaction, to manage costs, both our cost and the cost to the system, and to reduce the racial and ethnic disparities of the vulnerable populations we serve. We're in the process of applying to the NCQA for level three accreditation as a patient-centered medical home, in July, 2002. And the preparation for PCHM accreditation has encouraged our staff to focus on the continuum of care for their patients, that would ultimately improve outcomes. Our main goal for this centralized model is to eliminate unnecessary and redundant tests and avoidable hospital visits, coordination of care, improving our quality of care and access to care, wellness and prevention for our

communities that are predisposed to high rates of chronic illnesses, integrating our medication management to optimize our patient outcomes, and behavioral health integration.

We just moved to a brand new building in Roxbury, and we designed it around the NCQA patient-centered medical home model to maximize the positive patient experience. Our patients have confronted a lot of challenges, so it's important that when they come to us, they have an environment that's patient-centered and services that are patient-centered. We've also increased the effectiveness of the delivery of our care, to strengthen the ongoing relationships between our patients and our provider teams.

Currently, we're excited about the patient-centered medical home and excited that the Division is looking at ways to improve payments to primary care facilities, because we believe that the current funding is not adequate to sustain the work that we're doing. Care coordination for a community health center that serves a large, vulnerable population requires additional human resources. We utilize patient navigators, care coordinators, case managers, financial counselors, managed care referrals, to help with the coordination of care and really to reduce the burden on our primary care providers. Also, to be truly

patient-centered, we must schedule multiple visits at the same time, but currently, the health care reimbursement system does not support that. We have to depend on grant funding and fundraising activities. To enhance access to care and reduce unnecessary use of emergency rooms for non-emergent care, we have significantly expanded our urgent care clinic, which has been a huge source of access for new patients, but there are challenges with those as well. And I'm here also representing the other 51 community health centers who are also seeing the same payment issues, looking for care model change, and reimbursement that supports the innovations that we're currently utilizing.

Whittier is also one of the founding partners of the Boston Health Net, which is 17 community health centers affiliated with the Boston Medical Center, and in 2003, through that collaboration, we implemented an electronic medical records system through General Electric. And so through that, we're able to coordinate our care with the Boston Medical Center systems, but there are challenges with our other hospital partners. We've made significant progress and we're excited about the opportunities that the patient-centered medical home brings to the communities that we serve. Thank you.

KELLY: Good afternoon. My name is Dr. Jack Kelly. I'm Vice President for Central Mass Independent Physicians Association. CMIPA is a small physician, independent physician group in Central Massachusetts. We have 200 physicians. We have about 93 practices. We have 17 disparate EMRs and we cover 50,000 lives in Central Massachusetts. We're an institution neutral group. We are not affiliated with one in particular hospital or hospital system. We use all the facilities that are available to us in Central Massachusetts. We do have a number of at risk contrast, which we are at risk for, including Blue Cross AQC, Tufts Medicare Advantage, and the Fallon Senior. We're the only provider group in Central Massachusetts that cares for Medicaid patients for all the products in Central Massachusetts. We've received a number of awards for quality, as well as our data warehouse, and we continue to espouse the importance of independent practice in the practice of medicine, period. We do feel that it gives a good quality medicine going forward.

I, myself have been in practice for 30 years, all in internal, general internal medicine, jack of all trades, master of none. It's interesting to see where medicine has gone over those 30 years. When I first went into practice and for a great majority of it, practice of medicine was

reactive, not proactive. Nowadays, we're much more proactive. Our idea is to keep our patients healthy and not just treat them when they have to come in ill. The other interesting thing that's changed over this time is that when I came out of medical school, cookbook medicine was looked down upon. The importance of individual care was important, but individual thought was also important. Now we're seeing that there are -- that this is not the best way to give care, but there are treatments that are out there that we should be utilizing instead, across the board, for better outcomes going forward.

I am very happy to be here, to be I think the only representative of independent medical practices. I very much wish to thank the Attorney General's Office for this opportunity for that. I think our needs and our requirements are different than the large systems. I think very strongly, that our place in the health care continuum is critical and I look forward to being here this afternoon with you. Thank you.

BOROS: Thank you very much. So I'd like to start, where I sit, at the Division of Health Care Finance and Policy, we're a numbers based organization, so we work a lot with various datasets, including claims datasets and other

datasets and financial datasets. So I'd like to start with Mr. Pope, to talk a little bit about, just to provide a context that we can base our conversation on a little bit, talk about how Medicare went about creating one approach or one test of integrated care, through the Physicians Group Practice demonstration. So if you could talk a little bit about what that demonstration did, and then how you went about evaluating it and what the results were. I'd appreciate hearing that as a context for how we can talk about, the rest of the afternoon, care integration and the approaches and challenges that some of the providers have had.

POPE: OK, thank you. I'll make a few remarks on that. The Physicians Group Practice demonstration is actually something that had its genesis back in the early nineties. There was some work at Brandeis University, because there were some national physician expenditure targets called the volume performance standards, for physicians spending under Medicare, and the Federal Government was interested in determining -- having some sort of benchmark to judge physician spending under Medicare against. But those were national and there was a concern about well, maybe some groups or providers were doing a good job of controlling

costs and others weren't, but there was a single national target, so there was an interest in moving incentives down to a lower level, to the physician group practice level in fact, and that was sort of the basic idea that the demonstration started from.

I started working on it in 1996 and it actually wasn't implemented until 2005. So you can see that one of the challenges has been just a long time lag in sort of working these ideas through the system and getting them implemented, then evaluating and promulgating their results. So one thing at the federal level there's a lot of emphasis on now is so called rapid cycle evaluation and getting demonstrations and new ideas out quickly and getting the results promulgated quickly. So the Physician Group Practice demonstration, actually it was mandated by Congress in 2000. Medicare and Medicaid ship benefits, improvements and protection act, and the goals were, "To encourage coordination of health care furnished under Medicare, Part A and B, which is the hospital and physician side of Medicare, to encourage investment in administrative structures and processes for efficient service delivery, and to reward physicians for improving health care processes and outcomes."

So the real idea, the shared savings, I think Dr. Lopez mentioned the shared savings idea. The idea behind the Physician Group Practice demonstration, as opposed to managed care, was to have kind of a -- establish incentives for efficiency and quality, but with more of a carrot than a stick. So it's a so called shared savings model, whereas if the provider group saves money, they can share the savings along with the payer, with the insurer, but there's no downside financial risk to the providers. The providers are at a business risk if they invest in processes to improve their care management. That investment could be lost if they don't share in savings, but if they don't meet their expenditure target, they don't actually suffer a penalty.

It was also important, on the Medicare beneficiary side, that there was no lock in, so the traditional fee for service payment system continued and beneficiaries did not have to enroll in the program, so it was a model that focused on the provider side and pretty much let the beneficiaries -- you know, they didn't have to see a certain limited network of providers. They continued to have freedom of provider choice. So, the Physician Group Practice demonstration was a step, was sort of a transitional step between where we are, were, or maybe

we're not there any more, but a sort of traditional fee for service on managed care, to more of a highly managed global payment type of environment, so sort of a transitional system.

So the Federal Government solicited participants and ten large physician organizations participated in the demonstration, whose first performance year was 2005. There were no organizations in Massachusetts, although the Dartmouth Hitchcock Medical System in New Hampshire participated, and the Middlesex Health System in Connecticut participated. The demonstration ran for five years for those ten groups and performance was evaluated every year or so for each group. An expenditure target and quality performance targets were set, and then the group's actual financial performance, the per capita expenditures of their assigned beneficiaries, were compared against the targets to determine whether savings had occurred and how much of it would be shared with the provider groups.

So the results overall -- I was talking to Lois ahead of time and she said well, the results, as I've heard, are kind of mixed, and that's a fairly accurate characterization I would say. The demonstration, I think was a proof of concept and in fact, essentially the Federal Government has now morphed that into the accountable care

organization program in Medicare. So the Physician Group Practice demonstration was sort of a proof of concept of the shared savings type of model in a number of issues. There are a number of technical issues in setting expenditure targets, measuring quality, evaluating performance, and they were worked out during the course of the demonstration. But in terms of the savings, sort of overall, sort of results, financial results of the demonstrations were a small savings. There were some savings but they were not you know, not striking or dramatic.

You often hear people talk about low hanging fruit in the health care system, but it didn't appear that it was just really easy to go out there and save 10, 20 percent right off the bat or these groups participating in the Physician Group Practice demonstration really didn't achieve that level of savings, but there was some level of savings, pretty much oriented -- the savings were achieved from inpatient spending, from high cost patients, which is not surprising, because that's where the money is, the chronically ill people with high risk of expenditures, with many multiple chronic conditions. Groups that did well tended to control -- have to control both inpatient and outpatient spending. Some groups did well in inpatient

spending, but there was a balloon on the outpatient spending, and so they didn't do well overall. Only two of the ten groups achieved savings in all five years of the demonstration, and several didn't achieve savings in any, and these were sort of leading edge, vanguard groups that were kind of self-selected participants that were expected to be successful under this initiative. So it's a little bit sobering when you think of generalizing this to the general population of providers and even these vanguard groups, you know had some success but it was fairly limited.

So I think the sort of issue at this point is whether the carrot model, something like the Physician Group Practice demonstration, shared savings program, medical homes, whether that's efficient or whether it has to be more of a stick or sort of harsher measures, if you will, or maybe exposing providers to more downside risk, financial risk. And I know a number of the providers on the panel can speak to this and are assuming considerable risk. But the general population of providers out there in a lot of parts in the country are not. Also, on the beneficiary side, can something like the Medicare Physician Group Practice demonstration, which really focuses on providers and doesn't change the incentives for

beneficiaries, can that work, or do beneficiaries have to have some skin in the game through you know, limited networks, through lock-ins to certain provider networks, to having greater cost sharing tiered networks and so forth. Are those types of steps necessary to get costs under control?

JOHNSON: Thank you. And just to follow up, if you could speak a little bit more Mr. Pope, about the types of -- the organizational structures of the groups who were involved, of the ten PGP projects. As I recall, what struck me about looking at your assessment, is that no performance payments were earned by the five PGP groups that were part of integrated delivery systems, and there were other types of groups, whether standalone physician network groups. Can you talk about the implications of that for provider groups in Massachusetts that are organized in different ways.

POPE: So, nine of the ten participants in the PGP demonstration were integrated physician groups, and one was a physician network that was supported by a management service organization and sponsored by a hospital. So, a couple -- two of the groups were freestanding physician group practices and five were parts of integrated delivery

systems that included hospitals. One of our sort of evaluation issues or hypotheses going in was to see what the difference in performance would be, of different types of groups. The organizations that included a hospital, there was a hypothesis that perhaps they would be less active in cost control, because a lot of the savings were from keeping people out of the hospital. And in the Physician Group Practice demonstration, the fee for service payment system continued. So if you keep people out of the hospital, your hospital is going to forego that revenue for Medicare that would be paid under the fee for service system, so you might have a situation within an integrated delivery system where the physician components is participating and they might want to save money, but the hospital part may have a different view of savings from that part. On the other hand, some of the participants said it was actually advantageous to be part of an integrated system, because then you can coordinate the physician and the hospital, and have a coordinated approach to care, so there may be different factors that play there.

I think another important issue was the transmissions of incentives from these broader groups, and maybe some of the other people on the panel could speak to this. If you establish an incentive, kind of a high level group practice

or integrated delivery system level, how does that get translated down to the individual physician working in the practice, in terms of changing their practice patterns. I don't know if that addressed your question to some extent.

BOROS: I'd like to follow up on that question of independence. Dr. Kelly, you mentioned that you're the only independent physician association, but actually when I think about it, Frederica Williams is an independent community health center and Dr. Lopez represents a physician group as well, it's not explicitly affiliated with a hospital. So, varying degrees of independence among many of you. So actually the three of you, I'd like to explore that question a little bit more, building off of what Mr. Pope was saying. How does independence harm you and how does it help you in improving quality and reducing cost. So, maybe I'll start with Dr. Kelly.

KELLY: Yes, and I just want to -- when I mention independence, we're all -- we're not under one tax ID number. Everyone has their own individual ID tax numbers, which I think separates us from a number of other groups of independent docs. There's -- it's very -- it's herding minnows I think, when you're an independent practice and

you have again, as we have, 93 different offices and 200 physicians, and everybody is doing their own thing for so long. From our perspective, what's worked best for us is start from the bottom and work up, and by that I mean really utilizing the PCP as the base. We've become very aggressive with our PCPs in regards to monthly meetings, utilization review meetings, pod meetings, including the specialists in these meetings as well, to be able to cross thoughts back and forth. And also, what's actually helped significantly is with our contracts, we've been able to develop certain incentives for our PCPs, such that they have been able to move their book of business into areas that would be more of a value than at other institutions. And I think what this has allowed us to do is to really come together as a group, throw great ideas off of each other.

We have not been doing this very long, I'll be perfectly honest with you. Our first really risk contracts started in January of this year. It's been incredible to see the response of the PCPs in our group. Of course, we're only dealing with a hundred PCPs. Really, only 50 of those are adult PCPs and it's been incredible to see the fact that nobody wants to be the outlier, when you go to these UR meetings. There's been significant movement of

where health is delivered. There has been coordination of care greater than there ever was before and it's made me realize that even though we may be individual, independent unto ourselves, we're really coming together as a group in order to obtain a better end result for our patients and for our own association.

WILLIAMS: Being an independent community health center has given us a lot of flexibility to really focus on the needs of the community, being innovative. The way community health centers are structured, there are community health centers that are under hospital license and under their overhead structure. And for us, being an independent health center, we have the flexibility to partner with all the hospitals that serve our patients. So the needs of our patients come first. It also gives us the flexibility to really address the racial and ethnic disparities in health care.

We made a commitment to serve, to make the disparities in the community a priority. So for example, we're the only health center in the nation that has a very large low income male population. Forty-four percent of our patients are men. So we have the flexibility to open a clinic in a house of corrections, because that's where the needs are for our patients that have chronic illnesses. So we've

made a decision to -- we're the only federally funded public housing provider, so we made a decision to have satellite clinics in public housing developments, so we can address the social and environmental determinants to health, remove the barriers. So it's given us that flexibility, to make those changes, to be innovative, and we're seeing it in the clinical outcomes. Even though we serve a large community that is at risk for a lot of chronic illnesses, the fact that we're getting them early in care and seeing the results, whether it's diabetes patients or asthma, whichever one.

Kaiser Permanente just put out a report of 1,200 health centers in the nation, and we ranked in the top 70 as far as all the clinical outcomes that were measured. So it's given us flexibility. It's also given us the opportunity to hire the type of providers that share a vision and have a commitment to our mission. So we're not having hospital providers who are interested in research and teaching, which is great, I mean those are good things to do. But for us, we want to focus on the community based research, community based care, community based teaching, that will eliminate the racial and ethnic disparities. So we're able to provide incentive. So if you spoke to any of the health system, they will tell you that we are leaders

in the changes that we're making, that meets the needs of Roxbury, being our primary service areas.

Having that flexibility is wonderful, but also having the affiliation as one of the Boston Health Net health centers, has its benefit. In that, we were able to go to a private funder and get monies to support our health information technology. Otherwise, we would not have the reimbursement. Based on the reimbursement, we have, as a federally qualified community health centers, we are not able to afford the capital infrastructure that we really need to be this forward thinking health center that we would like to be. So having that partnership. But then again, Boston Medical Center itself are having their financial challenges, so I have dreams of having a patient web portal. Other things that we can really use to manage patients and increase access to care, but we're limited.

In looking at the care coordination, because of our relationship with the Boston Health Net, our external referrals to specialists, and because we are all on the same health information technology system with the 17 health centers, we're able to share information. It's a challenge with the other hospitals. So, getting information when people are in the hospital, getting information about the emergency room visits, those are a

challenge. So it has its benefits, but the continuous stress of resources and meeting the needs that are growing. I mean we are growing at a rate of about 20 percent a year and could do a whole lot more if we had the resources, but yet we don't want to lose our independence, because it means so much to the work that we're trying to do.

LOPEZ: I think with respect to Atrius Health, I think the fact that we have relationships with multiple hospitals is overall an advantage, and it's an advantage for our patients, as well as for our practices. We have the opportunity to choose and choose wisely, no pun intended, to choose between hospitals in any geographic area, based on their quality and their value. It can be a double edged sword in terms of getting the hospital's attention, but I think what we found is that if you work with hospital leadership, which ever hospitals you choose, if you work with them effectively, you can improve the processes and the work flows so that patient care is optimized, and certainly around transition. So we focus a lot, when we decide on a preferred hospital, we focus a lot on hospitals where the leadership is engaged and they're interested in working with us. And secondly, that they're willing to work with us around information transfer, which is a really

critical part of our integration strategy, so that we have ready and free access to them. Probably most important, that they're willing to work with us around transitions of care and discharge planning. It's really important that the hospitals return our patients to us, because we do feel accountable for the patient care, and trying to coordinate that requires some effort on the part of the hospitals.

I would also say that you know, hospital care is still important in terms of the overall health care scheme, and I think that the risk in ACO development and global payment is that you know, where some of the waste needs to come out of the system and the health care dollar saved, is going to be in hospital care. So we're sensitive to that and we've begun to talk to a couple hospitals about you know, some kind of risk sharing arrangement that's based on quality metrics such as readmission rate for instance, where both of us would benefit under a global payment by reducing the readmission rate, so that we can share some of the savings with them. So you know overall, I would say it's been probably more positive to have that flexibility.

BOROS: So Mr. Bradley, I'd like to turn the same kind of question on its head for you a little bit and say, as a hospital system with affiliated practices and centers, what

are the challenges for you in integrating care and building partnerships with various kinds of entities. And some of the challenges that we heard about from the independent groups are -- and focuses of their attention are areas of communications and thinking about how to better communicate, especially around discharge planning, around medical records. So, to the extent that you as a hospital are potentially looking to partner with various kinds of different entities, what are the challenges and opportunities that you see?

BRADLEY: Thank you. We have to be cautious about merely shifting what portion of the health system controls the health care dollar. It will do us no good as a society if the control goes from large academic medical centers to large physician practices, but the total medical expenditures don't stabilize or even go down. It's just different people be in control of the same limited dollars. And generally, what's driven -- in my opinion, what's driven health care has been two things. One is the rules around payment, which are not established by providers, they're established by insurers, either private or public, and the cultures that emanate from medical school and

nursing schools, et cetera. And I would add to that, business schools that train health care executives.

So, if we want to change the way that people behave, we have to change how we pay people. So, to the degree that it was a fee for service based system, established by third parties, people who are in the business of providing health care and are who are good at it learned how to maximize those systems. Unfortunately, what we've seen is you get great quality of care, sometimes you get leading edge innovation in particular places, but you get a lot of volume. Volume is driven because when rates are flat or rate increases are small, the only way to increase revenue is to drive volume, and that's not good. It's not good when it's in your stock portfolio, if you have one, if someone is churning your stocks so they can make money on volume, or if it's in health care, where folks are making sure that the expensive machines are being used or all the beds are being filled. So changing the way that people are paid, in my opinion and I believe in the opinion of the health system, is one of the critical approaches to changing the way that health care is delivered.

And along with the change in the payment methodology, I would say that really the biggest challenge is the culture change. And by that I mean, you know we have

generation after generation of patients and practitioners that have been trained from their medical school days, you know their other clinical trainings for nurses and other clinical staff, to the executives, and to the patients. They've learned how to use the system and most of the costs have been hidden from everyone, you know from the people that use the system. So we have to work with individuals and with populations as a whole, to understand that the current system is unaffordable. Quality is good but it could be great. Accessibility is better in Massachusetts than it's ever been, but it could be even better. We could shift the spending from the back end of health care on acute care, on end stage disease management, to the front end of health care, around health education, disease prevention, and we can start talking about the issues that really drive the health inequities in communities of color in particular and poor communities in general. And we don't do that.

So I think the notion that people have to understand that it's a new world and that it's a world where, if you're going to profit, you know if you're going to be a financially sustainable organization, whether you're a hospital or you're a physicians practice, or whether you're an insurer, that the way you're going to be measured in

terms of success is what's the quality of health of the patients that you're responsible for, and of the overall population; if you're a hospital, in your particular area, or if you're an ACO. And is that population getting healthier or is that population you know, continuing to be unhealthy. I truly believe that we're going to have to involve ourselves in -- as my colleague mentioned -- the social determinants of health.

It was only a couple of years ago, I was at the national meeting of the American Public Health Association, and there was a paper presented that said that 25 percent of all the cost in the country for health care were unnecessary, because they were going to serve populations that had health status that was way below the norm. And when you go and you look at that, you find out that these are communities of color, these are poor communities who don't have the economic opportunity. They don't have the housing opportunity, they have safe neighborhoods and safe communities. The public schools are not producing graduates at the level that they would in suburbia. And all of those social determinants, including racism, the effects of 400 years of racism that create the dynamics that exist, particularly in the urban centers, drive down

the health status of individuals and drive up the cost of care.

So we can do a lot of other things in health care that we've talked about, in terms of much better coordinated care, reducing duplication of services, incenting providers through ACO mechanisms, to keep people as healthy as possible, but we need to step out and start talking about the impact of racism on the health status of huge portions of our community, and at Baystate we're doing that.

Baystate Medical Center in particular, we're working in the communities. We've worked to set up the Mason Square Health Taskforce, which is a community run, community led organization, forty-five thousand people in the greater Mason Square community, which is made up of four neighborhoods. Very low health status, very low level of income. And rather than put out an RFP, to hire a company to teach diabetes management, we've elected to go out and work with the churches in that community, to work with the civic organizations, the business organizations, and the civic leadership in the neighborhoods, to dramatically increase the capacity for individuals to understand what drives their health care or their health status, and then to start organizing around things like we want a full scale grocery store, so that people don't have

to go out to bodegas, you know, and buy food that's expensive and unhealthy. So I guess I would just ask that you add to your emphasis, this issue of you know, of the social dynamics of health and how it relates to race and racism and ethnicity.

BOROS: Thank you. So let's shift the conversation based on some of the issues that you brought up, to the question of what does care integration really mean and then what are the challenges of it, because building off of your last comment about other elements that we should consider, my colleague, Commissioner John Auerbach is never shy about reminding me that it's not all about claims payments and medical services, but it's really about a broader public health mission, and the levers are all about -- are often in the community, not so much in the hospital or in the physician's office. So I'll open this up to the other panelists, to talk about what are the elements of integration that you are trying or would like to try, and what are the barriers today to access these other kinds of integration that you may not have been doing ten years ago. Let's start with Frederica Williams.

WILLIAMS: And it's wonderful that Commissioner Auerbach is always reminding you, because he started his career in community health centers. It is such a critical resource in the community. A study came out a couple of years ago that looks at this whole issue of social determinants to health, and it attributes 50 percent of what makes us healthy is our lifestyle and our behaviors, 20 percent is our environment, and only 10 percent is access to care. So in community health centers, that's what we're doing, it's that 80 percent that we're really focusing to address. Meanwhile, if you look at the national spending of health care, only 80 percent is in access to health care, when 80 percent of what makes you healthy. So it's really changing that, and one of the things that we've done in um, when you look at the social issues of the perception of the communities that we serve, whether it's valid or real, around racism, around access to care, one of the challenges we have is actually driven by reimbursement.

So as we look at our relationships and our affiliations, there was something that came out that basically said if you have an immigrant status of a particular level, you had to go to this particular health care system that we did not have a relationship with. So it's completely different missions, completely different

focus, and we in the interim had for example, women who were later in their pregnancy, did not have the language capacity, had a host of issues, and that created some challenges for us. But we did work out, with the hospital executives, and I think things seem to be working.

One of the things that we've done in the new building, in looking at the cancer disparities, cancer being the leading cause of death, we've integrated with Dana-Farber. Dana-Farber Cancer Institute has a cancer clinic in our health center. So on the fifth floor, we built a community based cancer clinic and I'm on the Dana-Farber board as a way of integrating into the hospital, and made a case to them to say, Dana-Farber is a wonderful place, but for people in Roxbury, they see it as the ivory tower, they don't see it as a place. But yet, somebody from Saudi Arabia could fly and feel entitled to go there, and someone from Maine can drive, and yet we're two miles away and people don't feel that they can access that. And Dana-Farber took the leadership, Dr. Benz specifically, in working with us, and he said well, when you find the money to build the health center, we'll build the cancer center. Well it took me ten years to find the money and we finally did.

But I will tell you that in a month's period, there were 35 people referred to that medical oncology clinic, and ten of them were late stage prostate cancer. These are people that would add cost to the system if they weren't caught early. These are people that even if we had diagnosed them and referred them, they would be lost in the system. So through our care coordination, having a Dana-Farber oncologist in our building really removed all the steps, so that when they were referred to Dana-Farber and the Brigham, they had almost a boutique level of care. So it improved their quality of care, it reduced the cost. It was early detection, early access to care, and hopefully, we also have a survivorship clinic. Those are the type of integration that I believe in, looking at being patient-centered.

And even, I mentioned to you earlier, we, because 80 percent of out patients present with psychosocial issues, integrating behavioral health with a primary care clinic, whether it's reimbursable or not, is our obligation. And it saves the system money, because people present for primary care visit, when really the issue is mental health. And so having the team working together and being patient-centered and not scheduling multiple visits, and making sure we're taking care of all of the patient's need when we

have them, the opportunity is now, but that creates some challenges. So really looking at these behavioral issues and reimbursing people that are focused on it, because if we don't change those lifestyle and behavioral mindsets, that just adds expenses. We're looking at when policy drives, where we can refer patients, to making sure that their shared vision with the people that we're working with, and also we want the type of integration that we've built with Dana-Farber and would like to build, because as we said, we're looking at, we've built an urgent care clinic where most of the times, we're not getting reimbursed for the visit. It's helping to reduce the emergency room visits, but what is the incentive to a community health center to do that?

When we look at the global payments, we're using lay staff that are not reimbursed, and if we were assigned an amount of money to say, you take care of patient A, and these are the clinical outcomes you need to meet and these are the patient satisfaction goals and these are the community goals, I think would really drive who we partner with, because it would be an organization that shares that same vision with us.

LOPEZ: I would say that the biggest, sort of obvious, the biggest difficulty in integrating the system is just weaving all the pieces together, right? So it's making the -- you know, all these health care entities are working to provide good care to patients, whether it's a skilled nursing facility, a VNA, a hospital, a doctors office. They're all working in their silos dedicatedly to do this, but it's pulling it all together, creating the links, creating the information exchange, developing common workflows, making it seamless for patients across the continuum, that I think is our greatest challenge.

I think secondly, somewhat to what the other panelists said, I think moving more of the care out into the community and in the home is a big challenge for us as well. You know, when we think about it, people spent .0001 percent of the time in the doctor's office. They spend even less time in the hospital, in their life. They spend more of their time in their places of work or in their home, and we need to figure out better ways in order to get at those lifestyle and environmental issues, how to touch patients more effectively in the home. We've recently affiliated with VNA Care Network, which is a large visiting nurse association, mainly to be able to develop some innovative ways of being able to touch patients in the

home, have the VNAs for our sicker and chronic ill patients be more connected to our practices.

I think that there are barriers that are artificial, that impede effectively integrating care. Some of these include the payment system. I think the -- for instance, with our VNA colleagues, they only get paid with very specific visits and very specific requirements, whereas we might want them to do other things in the home that they can't do because it's not reimbursable. Or even our medical homes health coaches are not reimbursable. Care coordinators who do outreach and work to keep the patients linked with their providers, again are not reimbursable. So those are issues.

Another big disconnect is around behavioral health. Behavioral health is an enormous component of the health care system. Partly, you know, with straight diagnoses of behavioral health and all the issues there, but it also underlies a lot of medical utilization. Numerous studies have shown that for the same medical condition, if the patient has comorbidities around behavioral health issues, usually the utilization of emergency abuse and hospital abuse and so forth, is double. What we've done is to disconnect the behavioral health community from the medical community, in terms of payment rules and the way insurers

have set up behavioral health carve outs. In addition, the concerns around confidentiality have you know, rightly or wrongly limited information transfer, so that you can kind of know that there's someplace where someone knows the whole picture of what's going on with the patient. So that's kind of been an impediment.

And then I think lastly, I would just comment that one of the most rapidly growing insurance products are the PPOs, preferred provider organizations, and the largest one of all is Medicare, which doesn't require the patient to choose a primary care physician. I think this is a problem because ultimately, if we're going to reduce waste in the system and coordinate care, at least having to choose a personal physician sort of separate from authorizations and referrals, just identifying that in the system as your primary care physician is an important component. PPOs, because they don't do this, they don't facilitate coordinated care.

BOROS: I'd like to hear from Dr. Kelly about integrated care and what it means for an organization like yours, and then maybe I'll bring it back after you have a chance to address that point, to Mr. Pope, and we can talk about payment arrangements and some of the challenges there.

KELLY: Thank you very much. You know, I think that IT connectivity and data is critical to integrating anything, and certainly from the patient, with the patient portal, to the doctor, to the hospital, to the SNF and back again. If we don't have that connectivity and that ability to communicate back and forth, we're not going to be successful. One of our problems, being a physician group, is that there's less money available for us to integrate systems. There's a bit of a disconnect or equality in regards to compensation, with as opposed to say hospital systems. This was actually brought up by the AG, I think last year. And so it makes it difficult, from our perspective as independent physicians, to be able to coordinate and integrate as well as I think some of the large systems have. That hasn't prevented us from trying and we certainly do continue to do that, but it isn't to the optimum that it really needs to be, and I think that not having the funds available to do that make it very difficult.

It's also, I think important from our perspective, to engage our specialty care physicians. We're being able to do that with our PCPs, but I think, as it's been brought up by a number of the panel members here, there has to be more

engagement of the patients themselves in regards to their own health care. I think we have gotten to the point where we've let the patient off the hook a little bit about their own health care, and certainly, Ms. Williams has mentioned greatly, as has Mr. Bradley, in regards to the effect it's had in the communities of color, but all communities. I mean it's across the continuum. I think Mr. Bradley mentioned 25 percent, I think was what the cost was. Well, that other 75 percent is the other communities, and we're just -- our patients are not being held as accountable as I think they really need to be, in being able to bring down the cost of health care, prevent an upswing of that cost of health care, and really improve the health care that we can deliver to our patients in the long run.

BOROS: Mr. Pope, I wanted to shift the conversation. Several people brought up the question of payment as being a barrier or being related very much to what providers are able to provide and the kinds of connections they are able to make. So I wanted you to speak a little bit to your observations, both in the PGP demonstration and as you're moving forward to ACOs, specifically around, if you could speak again. I think you mentioned earlier that you believe potentially downside risk might be an important

determinant of provider transformation, but also the issue that Dr. Lopez brought up, about having one primary care provider associated with one patient, which I think has been a challenge with the Medicare demonstrations and the freedom of choice for patients. And it's not exactly the payment system explicitly, but I think very much related to how providers see the risk and see their attachment to the risk.

POPE: Well, in payment systems in general, there's sort of a spectrum. One on end, you have a fee for service, which is kind of where we've been and where a lot of the world still is and most of Medicare is still paid under that, where it's a piece rate or a payment per service. And on the other side you have so called global payments, or what used to be called capitation. And fee for service has some advantages, particularly regarded to access, you know access to care, as I think has been mentioned, is good, but it has the disadvantage that there's no global budget or constraint on the system, so the cost control is not so good. On the other end, you have global payments or capitation, where it has better cost control because there is an overall budget on the care, sort of a per person per year, per member per month type of payment, but it raises

concerns about access and providers stinting on care, because under a flat payment, the provider will actually make more profit if they provide less care. So it's kind of the conversive fee for service, you make more money if you provide more care. Under global payments or capitation, you make more money if you provide less care, so you may have too little access at the other extreme.

So that's led to interest in some sort of intermediate types of steps that have various blends of fee for service and capitation, various levels of upside risk and downside risk to providers. A couple prominent examples of those are shared savings, which we've talked about, where the provider can share in the savings that they generate, so there's an upside risk but there's no downside risk. And also bundling or episode based payments, where you have a flat payment but not for all of care, but instead for particular bundles around hospitalization, say knee surgery or hip replacement. There might be a bundled payment that would incorporate not only the hospital portion, but the physician portion, the post acute care, the rehabilitation. So the challenge in the payment system is to try to get these various blends and incentives of risk to the providers. And there's the patient side too, which we can talk about, so that there is sufficient access, but there's

also cost control and the providers are competing based on quality and value and not on risk selection, on selecting, trying to attract just the healthiest patients, which is a big concern under the more bundled or capitated things that providers can do better financially by attracting the healthiest patients who cost the least. So there's some of the types of issues that occur with payment systems.

With regard to the patients choosing providers, I mean ultimately, you have to affect the patient behavior, the patient care, as well as the provider, because patients may doctor shop, they may demand care that providers may find it difficult to turn it down. So one model -- there are various models that are doing that, but one model is the so called gatekeeper model, where an insurance plan enrollee is required to choose a primary care doctor who is the gatekeeper for their care. There may be referral requirements and providers don't have total freedom of provider choice. So this is a difficult issue, because as we found out with managed care in the 1990s, when there were attempts to put a lot of restrictions on patient choices in which providers, patients can see, there was a lot of resistance to that and a lot of patients didn't like that. I think Rick mentioned PPOs are a large form of

health insurance because they do ensure freedom of provider choice.

So one possible compromise here is to allow freedom of provider choice, but to require an additional payment for patients that see more expensive providers. If a patient can still choose to go to the expensive academic medical center for their hospital admission, but they're going to pay more from that, so you don't have an absolute restriction like you know, this hospital is not in our network. But instead it's like well, you can choose the expensive academic medical center, but if you make that choice you'll pay something extra for it. So it gives the patient an incentive to choose a lower cost provider.

JOHNSON: Just to follow up, because one of the things I think Dr. Lopez mentioned, about the trend towards PPO products, and I think the health plan testimony into this hearing shows that there really is a continued migration, both from fully insured to self-insured and from HMO to PPO, and yet we're talking about things that might -- payment as a barrier and downside risk is maybe providing additional incentive to providers. But as we're talking about incenting providers, we're talking about integration and taking on risk, but how do the providers on the panel feel

about -- how can you -- where are we going here in terms of, do we want to take on more risk for patients that we can't control, we don't know their phone number, if they haven't chosen us as PCPs, or with self-insured, how do we shift risk in those kind of circumstances. If you could talk about that challenge.

LOPEZ: Well, a couple things. One is that when we've looked at PPO patients and working with one of the health plans and looking at patterns of care and trends of care, it turns out that there's a pretty close correlation that we were able to make, that matched up with the health plan, around who we thought this patient's primary care provider was; like a correlation about 90 percent. So that in fact, PPO patients, often the vast majority of them, often will get their care within some circle of providers and usually there's a generalist at the center of that. And although they have the choice and although some care is outside of that circle, the vast majority is within it. In fact, the Pioneer ACO used similar type logic and came up with what we had projected as our possible Pioneer ACO population, was very close to what Medicare came through. So given that and given the overwhelming advantages, at least in our system, for prepaid or global payment, we are certainly

willing to take risk on PPO patients. Just like the Pioneer ACO, patients that are attributed to us, because we know the vast majority are going to get care within our system.

I would also say that you know, there's a saying that the best fence is a green pasture. So you know, to the extent that we can make our system accessible, friendly, easy to use, high quality, patient-centered, our patients will stay with us when they need care. So you're absolutely right, there is this market migration towards PPO type products that sort of seems like it's in contradiction to assuming global risk, but in fact, if you really look at patterns of care, it probably is doable. We'd prefer to have patients select a personal physician, but that's not always the case. I think the other thing in terms of self-insured, that's more of a financial issue, of how to figure that out. We've had some arrangements with payers to work on that, but I can't speak to it actually.

BRADLEY: From a Baystate Health standpoint, and I think particular from our insurer, Health New England, it's very difficult to take on risk responsibility for a population that you no control over. And by control I mean just any confidence that they're going to be in your network for at

least a year. Maybe part of the behavior that has to change is this expectation on all of our parts that we can go anywhere, any time, to see any provider, notwithstanding that someone else is paying the bulk of those costs. So I think there needs to be some rationalization of sort of cost containment as a priority and unlimited access to specialists and sub-specialists throughout the state. And I think if you have a panel, if you have a network, as Dr. Lopez was saying you know, that's green enough, the pasture is green enough, there's enough high quality primary care physicians and specialists and sub-specialists in it, and that you develop, through your medical homes, a very close relationship with the patient and the patient's family, because really these days we're talking about not just treating a patient, we're talking about treating the family as a whole. You know, I think the behavior change can happen willingly and not have to force folks.

I would raise this issue around risk. When we talk about risk -- and I'm not sure that everyone really knows what we're talking about, but when we're talking about sort of the downside risk, we're talking about whoever controls and makes up that ACO, being responsible to make sure there's enough assets, financial assets in that group, whether it's a very large physicians practice functioning

as an ACO or it's a hospital or it's an insurer or it's a health center. Right now, the Division of Insurance is charged with the responsibility of making sure that there's enough capital reserves tied to the insurers, to make sure that those patients and those policyholders, are able to get what they need when they need to get it. Given the limited amount of dollars that are out there in the physician practice world, smaller hospitals, I mean this is an issue that has to be dealt with sort of straight on. I mean there has to be some guarantee, if you're going to join an ACO or some facsimile, that someone is looking out to make sure that on the downside risk, there's assets to take care of it. And I think that -- you know, if you can't find money to do electronic medical records, for some of the smaller practices and smaller hospitals, think how difficult it is to pull together that type of risk profile.

BOROS: I think that's a good segue to the last two panelists. So we have about ten minutes left and you can wrap up on this point. I think I've heard from both of you that increased flexibility around reimbursement would be helpful and increased investment kinds of payments would be helpful. But based on some of the comments and your position, I think that taking on more and more risk might

be something that is a barrier to these kinds of payment arrangements. So how do you see that, and maybe start with Dr. Kelly.

KELLY: You know, I think that obviously, it's a tricky proposition. However, I think if there were two -- two aspects would really go a long way in allowing us to be able to do that and do it successfully. Number one would be the data, being able to get the data. It is absolutely critical. The other is, I'm sure there are attribution methodologies that the PPO could use in order to give you a rough list of those individuals who would fall under your criteria. And I think if you had both of those, and especially in the populations that we're used to in CMIPA, basically often has very mature populations; populations where there's a very strong relationship between the PCP and the physician and the physician's family. I think if you have that opportunity list and you have the data to go along with it, I think you'd be very successful in managing those individuals.

WILLIAMS: For us as a community based health center that serves a significantly large low income population, there are several issues that would come with risk. When we were

participating in capitation with the Boston Health Net plan, with the payment system, you are assigned a patient based on their geographic location. So if that -- and many times, many of these patients don't even have a relationship with us but yet, we're taking on risk for them. And one example we found is of the panel of people, we had two patients that consumed millions of dollars, that we didn't have any information on, until we received the information retroactively from the insurance company. Now if we knew ahead of time, we would be case managing those patients ahead of time. So again, having the information, but also, as a primary care facility that serves people that bring different types of issues, we don't have reimbursement that looks at the intensity, the RVUs that look at what it takes for a provider that has a large chronically ill patient population.

There was also a time where patients that were reimbursed through the free care pool, were encouraged to go to health centers, because hospitals didn't want them. So then we end up with that risk, with no one wanting to share it with us. So looking at a particular population that typically would end up in community health centers, and looking at how we share the risk, and giving us the

information ahead of time so we are proactive in how we manage the patients would be helpful.

BOROS: Well, we have a few more minutes, so I'll do a lightning round. As we look forward to this role, we spend a lot of time talking about payment and a fair amount of time talking about some strategies for integration and where you're looking at different integration opportunities. For the lightning round, what I'd like to talk about, and I'll try to hear from all of you, is what should we be measuring on the outcomes or quality side, in order to evaluate that patients are getting access to the care they need? So, if everybody could spend maybe a minute answering that question, what outcomes or other kinds of measures should we be looking at, in order to evaluate the performance of an integrated care system. If you don't mind, Mr. Pope, we'll start with you and go down the line.

POPE: Well, that's an interesting and important question. Obviously, in the financial side, we have the claims data and the expenditures we can look at. It can be challenging however, to look at especially smaller provider units, at their financial performance, because there's a lot of

fluctuation in medical expenditures normally, and very expensive patients that are somewhat random; the million dollar premature babies and so forth. So it can be difficult to evaluate financial performance and there are a number of adjustments, risk adjustments, for patient health status and so forth, that are important to make, that are technically challenging. So I would say that the measure of -- on the quality side, there are a lot of process measurements, but I think we have a ways to go in linking the process measurements to the ultimate outcomes of interest and health status and so forth.

LOPEZ: I would say that the core of the measurements of success would be around the triple aim. So you know, per capita cost of care, the patient care experience, which is now in consumer reports, and quality measures. And then I think around the quality measures, I think particular attention ought to be paid to true outcome measures in chronic diseases, as opposed to process measures. Secondly, there ought to be more emphasis on preventative and lifestyle measurements, to address what was brought up in the panel discussion, around dealing more effectively with lifestyle and behavioral issues as preventing costs and better quality downstream. And then lastly, as we've

been struggling on the statewide advisory committee around integration measures that measure how well we do connect the hospital to the SNF to the ambulatory site, to the home services; measures that show that the system is working at an integrated whole.

BRADLEY: I would say total medical expense is something that we ought to focus on like a laser. I would agree with Dr. Lopez around the triple aim quality measures. The last thing we want is for every state to be coming up with their own quality measures. Medicare and ultimately Medicaid, should be able to agree on what the quality measures should be. If we're involved in those discussions at the provider level, we should be able to use those for commercial insurers also. We should be measuring the population health for the group that we're responsible for and I would argue that there probably should be some regional collaboration between either health providers or ACOs, to collaborate on the overall population health for a geographic area, because over time, these patients are going to migrate from one, say ACO to another, if that's the direction we end up in. So everybody sort of being all in, as the Governor likes to say, on a population in a particular geographic area, means you can spend money

improving their health, even if they end up not being with you at some point in time, because someone else that you're not improving their health on now, someone else is responsible and should be doing that.

Consumer satisfaction should be an important measurement and I would just add that I think we should be measuring the percent of TME that's expended on public health investments and health education and prevention, and then in terms of how much is being spent on highly integrated care, both personnel and the mechanisms there. Thank you.

WILLIAMS: Standardizing the reporting to track information, because for us that is an issue; getting different requirements from different insurers would be helpful. And so standardizing the reporting for integration efforts would be a good place to start. But also, appropriate incentives for innovations. So some of the things that we've provided that works for our community are medical group visits for people that have diabetes, or medical group visits to address infant mortality. So those would be something.

From a primary care provider point of view, giving us incentives for reducing readmissions, chronic disease

management, emergency -- unnecessary use of emergency room, and making sure that we have availability for primary care appointments, so people have appointments when they need the appointment. Those should be key, I believe, in addressing, monitoring and measuring the success of the integration in terms of access, quality and cost.

KELLY: I was just going to say, I was not going to put in a plug for Andrew Dreyfus and AQC, access quality and cost, but that's it right on the button. I think access is already measured somewhat, at least from a PCP perspective, with MHQP, regards to patient satisfaction, wait times, access to physicians. No sense in reinventing the wheel on that, but maybe using the data that's already there and being able to expand on that. Access to hospitals and in that I mean maybe in regards to specialists being able to get OR block time for surgeons, and how does the hospital respond to that situation. Patients being able to get studies done at a hospital in a timely fashion, and are quality rehabilitation facilities available to these patients as well. So I think all of those can be measured and would give us answers on access and how we're doing.

Quality. You know, I think that again, there's already been some work on that regards to the Leapfrog

initiatives and hospital compare. I think quality in regards to the PCPs, we see that again with the MHQP and the preventive measures and how physicians are doing in performing from that perspective. One concern I think, is that we tend to rely more on process data rather than outcome data, and I think that that's -- you know, as we move forward, it's the outcome data that's really going to be able to drive how we're doing, rather than the process data. And I think also, as a PCP, a consistency of quality measures. Feds have a certain number, state others, and different health plans others, and it becomes very confusing, and I think there ought to be one set of quality measures that we can all be measured against and feel comfortable doing.

And in cost, there has to be transparency of cost data. I mean, we really need to know. I am the buyer of the groceries and I don't know what it costs to go to a particular grocery store. So it really makes it very difficult, from a physician's perspective, to be able to control costs, when I have no idea what they may be at one place as opposed to another, with quality being equal. I don't know what the cost of the medication I am prescribing and it gets very discouraging when you think you're doing

well by prescribing a generic, and realize the ridiculous, prohibitive expense of that generic medication.

Concluding Remarks

BOROS: Well thank you very much everybody, for your time this afternoon. This has been a wonderful conversation and you raised a lot of questions and answered some questions as well. I appreciate you spending your time with us this afternoon. I invite you to join us tomorrow and pay attention to the continued conversation that we're going to be having tomorrow. We are reconvening here again tomorrow at 9:30 in the morning, and we will be having -- I'm sorry, 9:15 tomorrow morning, and we'll be having two panels tomorrow. At around 9:30, we're going to start the first panel, which will be on shifts in the health care marketplace and looking at some of the experience under Chapter 288, and then in the afternoon, we're going to have a second panel on providers that are neither large physician groups or hospital organized PCPs, but rather ancillary providers like rehab providers and home health, and their experience, as well as the consumer experience, in the health care system. So thank you for your participation and thank you for our support here at Bunker

Hill, I appreciate that as well. Until tomorrow, thank you.

END OF AUDIO